UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, et al.,	)	
	)	Civil No. 18-2340
Plaintiffs,	)	
v.	)	
	)	Washington, D.C.
CVS HEALTH CORPORATION, et al.,	)	June 4, 2019
	)	Day 1
Defendants.	)	Afternoon Session

TRANSCRIPT OF MOTIONS HEARING
BEFORE THE HONORABLE RICHARD J. LEON
UNITED STATES DISTRICT JUDGE

APPEARANCES:

For the United States:
Jay David Owen
Peter Joseph Mucchetti
Scott Ivan Fitzgerald
Jesus Manuel Alvarado-Rivera
U.S. DEPARTMENT OF JUSTICE
Antitrust Division
450 Fifth Street, NW
Washington, DC 20530

For State of California:
Malinda Lee
OFFICE OF THE ATTORNEY GENERAL/CA
300 South Spring Street
Suite 1720
Los Angeles, CA 90013

For State of Florida:
Lizabeth A. Brady
OFFICE OF ATTORNEY GENERAL/FL
PL-01, The Capitol
Tallahassee, FL 32399-1050

(Appearances continued on next page)

APPEARANCES (CONTINUED)

For CVS:	Rani A. Habash Michael G. Cowie Michael H. McGinley DECHERT LLP 1900 K Street NW Washington, DC 20006 -and- Jonathan Bradley Pitt WILLIAMS & CONNOLLY LLP 725 12th St. NW Washington, DC 20005
For American Medical Association:	Henry C. Quillen WHATLEY KALLAS LLP 159 Middle Street Suite 2C Portsmouth, NH 03801 -and- Henry S. Allen, Jr. AMERICAN MEDICAL ASSOCIATION 330 N. Wabash Chicago, IL 60611
For AIDS Healthcare Foundation:	Sean P. McConnell Christopher H. Casey DUANE MORRIS LLP 30 South 17th St. Philadelphia, PA 19103-4196 -and- Joseph J. Aronica DUANE MORRIS LLP 505 Ninth Street, NW Suite 1000 Washington, DC 20004
For Consumer Action:	Andre P. Barlow DOYLE, BARLOW & MAZARD PLLC 1110 Vermont Avenue, NW Suite 715 Washington, DC 20005 -and- David Alan Balto LAW OFFICE OF DAVID A. BALTO 8030 Ellingson Drive Chevy Chase, MD 20815

Court Reporter PATRICIA A. KANESHIRO-MILLER, RMR, CRR
U.S. Courthouse, Room 4700A
333 Constitution Avenue, NW
Washington, DC 20001
(202) 354-3243

E X A M I N A T I O N S

E X H I B I T S

AFTERNOON SESSION

(2:10 P.M.)

THE COURT: The witness can resume the stand.

NEERAJ SOOD,

having been previously duly sworn, was examined and testified further as follows:

THE COURT: You remain under oath, Doctor.

You may proceed when you're ready.

MR. QUILLEN: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. QUILLEN:

Q. Before the lunch break, we had started to talk about potential efficiencies associated with this merger. And I believe you had started with the idea that the merger would promote innovation.

Do you want to pick up there.

A. Sure. Let me just -- if you will allow me to start with a quick summary of the arguments before the efficiency claims.

So with the merger and without the divestiture, what happens is, in every PDP market, we have loss of Aetna as a competitor, and in every PDP market, there is an increase in market concentration because CVS and Aetna were competing in every PDP market. With the divestiture now, we still have loss of Aetna as a competitor in every PDP market, and we

have an increase in market concentration in every PDP market because Aetna and WellCare were competing in each one of those 34 PDP markets. And we have discussed the evidence that the loss of a competitor and increasing market concentration will, the evidence says, lead to higher premiums.

So now let's focus on the efficiencies. We also discussed the efficiency claims within the PDP market, and we said that this is not a merger within the PDP market because with the divestiture Aetna and CVS are not merging in the PDP market. Therefore, there are no PDP market-specific efficiencies that can arise.

So now let's look at the efficiencies outside the PDP market and what they might be.

So the first efficiency we discussed, potential efficiency, which was claimed by CVS is this would promote innovation in healthcare delivery through these healthcare hubs. And I discussed that typically the way innovation should work is you innovate, and if consumers like what you've done, you're providing a service at a low cost and good quality, then you will attract more consumers. But what this seems like, it's backwards. What you did is you bought Aetna and its 20 million subscribers, and now you're going to try to funnel them or steer them to your new model of healthcare delivery but now these 20 million subscribers are

not available to other innovators who might have had better ideas or who could provide the same service at a lower cost or better quality.

So, for those innovators, these customers are absent, and those innovators will suffer as a result. So I don't think this will promote innovation, but it might actually lead to a decline in innovation in healthcare delivery.

The other proposed benefit of this is that they've said, look, we, at CVS, have access to pharmacy data, and now we're going to buy Aetna, which is a health insurer, so now we're going to have access to the medical data, and we can combine the pharmacy data and the medical data to, say, better design the drug benefit.

So one example of that would be, you know, suppose there's a drug that lowers your healthcare costs, so you want to provide good coverage for that drug if you're integrated because you know that even though it increases your expense on the drug side you lower your expense on the medical benefits side. But if you look at what Aetna says, Aetna says -- this is on slide 14 -- so Aetna says, when they sign -- so Aetna signed PBM services agreement with CVS. So this was about 10 years ago. And when they signed that agreement, they clearly said -- they said, we retain our PBM and our ability to integrate medical care with clinical and pharmacy programs and actionable data. So what they're

saying is they were already doing what they claimed to be efficiency specific to the merger. They already, without this merger, had the ability to integrate medical data with clinical and pharmacy programs.

So I don't see why this merger is needed to integrate the medical and pharmacy data. You could do it outside the merger.

As a professor at U.S.C. or as a healthcare researcher, when I do research on healthcare, I have access to combined pharmacy and medical data. So if I, as a researcher, can get access to it, I'm sure a big company like Aetna or CVS can get access to the merged data.

The other thing they said was, look, if you combine this medical and pharmacy data, we can make CVS's pharmacists more effective at counseling patients. Well, what I feel is, if you truly want to make a pharmacist more effective at counseling patients, what you need is the medical record data. You need the data from the patient's doctor. Like the healthcare claims data is just medical bills. They don't tell you the clinical detail that you would know to manage a patient. I'm no doctor, but I believe that if someone is counseling me, I want them to have my doctor's notes with them. This merger doesn't enable them to have those doctor's notes.

The third efficiency claim is -- if you think about

this, maybe CVS and Aetna integrate, and that makes CVS a better PBM for Aetna. But at the same time, when it creates incentives for CVS to be a better PBM for Aetna, through input foreclosure, it also creates incentives for CVS to be a worse PBM for any plan that is competing with Aetna.

Now, if you look at the number of beneficiaries CVS has, that's about 90 million that they represent in their PBM business. And roughly 20 million are Aetna subscribers. So these 20 million will potentially benefit because now CVS is going to be a better representative or a better PBM for Aetna. But the other 70 million are going to be worse off because those other 70 million potentially compete with CVS and Aetna in insurance markets and their CVS now has the incentive not to provide the same level of service as they're providing to Aetna. So, in some sense, there is a potential benefit to 20 million, but at the same time, there is a potential harm to 70 million.

Finally, suppose this benefit arises. How will it benefit the public? It will only benefit the public if the savings are passed back to the consumers as lower premiums. So the idea is CVS and Aetna are one firm. They come up with a better benefit design. That should lower premiums and -- that should lower their costs, but whether it lowers premiums or how much it lowers premiums depends upon competition in the insurance market. So if there isn't a lot

of competition in the insurance market, those cost savings will not be passed on to consumers, or some of them will be, but majority or a large fraction of those cost savings will not be passed on to consumers. But if the insurance markets are competitive, then a high fraction of those cost savings are passed on to consumers. And the evidence is that health insurance markets are very concentrated.

So given that, it is likely that a significant fraction of the savings will not be passed on to the consumers even if they arise.

Q. What does the economic literature say about whether previous mergers in the health insurance industry were good for consumers?

A. Sure. So, on slide 21, I have quoted what -- so in the *United States v. Anthem* case, several health economics or economics professors submitted an amicus brief which summarized the evidence on the effects of health insurance mergers, and I was one of the cosigners on the brief. It surveyed the entire literature in this area, and we were all independent professors, we were not representing either party in this case.

And the summary of that work says, "This body of work finds that consultation in health insurance markets does not on average benefit consumers. Although greater insurance market concentration tends to lower provider prices, there is

no evidence the cost savings are passed through to consumers in the form of lower premiums. To the contrary, premiums tend to rise with increased insurer concentration."

So what this is saying is, when insurers merge together, it increases their bargaining power with providers of input. So you do see some cost savings, but those cost savings are not passed to consumers.

In the end, what you see is that increase in market power as a result of this merger leads to an increase in premiums for consumers.

THE COURT: And an increase in profits?

THE WITNESS: And an increase in profits. Because if you're not passing on the savings to consumers, then those savings are going to represent increase in profits for you.

The other kind of quote I have is from the congressional testimony of Professor Martin Gaynor, who is one of the leading experts on healthcare policy or healthcare antitrust policy. And he talks specifically about efficiency claims related to healthcare mergers. So what he notes is, "While the intuition, and the rhetoric, surrounding consolidation has been positive, the reality is less encouraging. The evidence on the effects of consolidation is mixed, but it's safe to say that it does not show overall gains from consolidation. Merged hospitals, insurers, physician practices, or integrated systems are not

systematically less costly, higher quality, or more effective than independent firms."

So what he is saying is, across a whole variety of healthcare mergers, you don't see strong evidence that efficiency improves or costs go down.

And what the prior evidence was saying is, when insurers consolidate, there is strong evidence that premiums go up.

BY MR. QUILLEN:

Q. In your opinion, is there anything about the various markets in which CVS participates that would cause this merger to buck the trend that these researchers have identified?

A. I don't know of any such factor.

MR. QUILLEN: I have no further questions.

THE COURT: You may step down.

THE WITNESS: Thank you, Your Honor.

THE COURT: Thank you.

(Witness excused)

THE COURT: Who will present the next witness?

MR. BARLOW: I will, Your Honor.

THE COURT: All right.

MICHAEL WOHLFEILER,

having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. BARLOW:

Q. Dr. Wohlfeiler --

A. Hello.

Q. -- can you state your name, please, and spell it for the record.

A. It is Michael, M-I-C-H-A-E-L, Wohlfeiler, W-O-H-L-F-E-I-L-E-R.

Q. And where are you employed, Dr. Wohlfeiler?

A. I'm employed with AIDS Healthcare Foundation.

Q. And you'll see on the table in front of you your CV. That is marked as AHF 1. That's your CV; correct?

A. Yes, that is.

Q. I'm going to talk about some of your background. I'm not going to go into great detail on it.

But first off, what is the AIDS Healthcare Foundation?

A. So AIDS Healthcare Foundation, or AHF, is a nonprofit organization that is a provider of medical care to patients with HIV or AIDS. We're what's called a safety net provider. We take patients regardless of their ability to pay.

Q. Okay. Could you explain that safety net provider concept in more detail.

A. So, again, a patient with HIV or AIDS who needs care is accepted at -- can receive care at AHF. It doesn't matter

if they have a payer source at the time. We will provide care. We will do our best to get them onto -- find a payer source for them.

The other thing that we do is we provide what are called wrap-around services. We provide a lot of additional services that you wouldn't find in, for instance, a private practice. We have a staffing model that our clinics have an RN on site, we have special positions called benefits counselors, and we have case managers, and referral coordinators; a lot of extra services that you would not normally find.

Q. The safety net provider status, is that pursuant to federal law?

A. Well, there is -- safety net provider is used in, for instance, the 340B -- what is called the 340B legislation, which specifically applies to nonprofit safety net providers like AHF and affects at what price we can purchase medications. It allows us to purchase medications for patients at a discounted price.

Q. Can you talk a little bit about AHF's operations in the United States?

A. Sure. We have been around for I think it is 31 years now. Started in Los Angeles as an AIDS hospice organization back in the days when HIV and AIDS was really a death sentence. And then, as things got better, AHF opened up

clinics to treat patients with HIV and AIDS. And then we consistently expanded so that now we've got over 60 clinics in 15 states and the District of Columbia. We're taking care of domestically about 35,000 patients. We've also got a global program where we're in more than 40 countries. And worldwide AHF is taking care of 1.1 million patients with HIV/AIDS.

Q. In addition to the roughly 60 clinics, do you also have a network of pharmacies?

A. Yes. Part of our model is that we have tried to create a one-stop shopping for patients, and we've also recognized the importance of the pharmacist-patient relationship. And so as a result, most of our clinics, unless they're very small and have a low census, have embedded within them an AHF pharmacy co-located.

Q. Co-located?

A. Yes.

Q. And your position with AHF currently is what?

A. So I'm Chief Medical Officer. As that, I run AHF's Domestic Department of Medicine, which means that I'm kind of ultimately responsible for all of the clinical care that we provide.

Q. And do you have firsthand knowledge of AHF's business?

A. I'm sorry? AHF's?

Q. Business overall?
A. Yes. Yes. Again, I run the Department of Medicine, but I am very familiar with our pharmacy business, our managed care business.
Q. Do you serve on any executive committees?
A. Yes. I serve on -- the executive committees are the highest level committees, and I serve on both managed care exec and pharmacy exec at AHF.
Q. How long have you been the Chief Medical Officer?
A. It will be six years in August.
Q. When did you join AHF?
A. I joined AHF in September of 2011.
Q. And you're a practicing physician?
A. Yes, I am. I'm a physician specializing -- in private practice -- specializing in HIV/AIDS since 1990.
Q. Are you a credentialed HIV/AIDS physician?
A. Yes. I'm credentialed as an HIV specialist by the American Academy of HIV Medicine.
Q. In addition to your executive duties with AHF, do you currently treat HIV/AIDS patients?
A. Yes, I still treat patients.
Q. Can you explain for the Court how the treatment of HIV and AIDS has evolved from the time you began practicing in 1990.
A. It's been a dramatic change. I mean, when I

started -- I really started seeing HIV patients during my residency in internal medicine, which I did in Miami, which was one of the epicenters of HIV. And back in those days, it was really felt that everybody who was HIV-positive would progress to AIDS and everybody with AIDS would die. And that was pretty accurate. I mean it was just nothing but death for many years. It truly was a death sentence. And we were just trying to keep patients -- extend their lives initially and, hopefully, give them slightly better quality of life. But there was no ability to really control the disease long-term in the early days.

Q. What is the current state of treatment that you're seeing --

A. It is very different. It started to change in around 1996. And I would say it is really since the 2000s that things have changed dramatically. Now the vast majority of HIV patients can be placed on medication regimens, which typically involve at least three drugs, and we can -- we can't cure them, but we can get the virus suppressed to undetectable levels in their bloodstream, and that allows their immune system to repair and to stay relatively strong, and these patients can remain now stable. It has become a chronic illness.

Q. What is your purpose in testifying in these Tunney Act proceedings today?

A. So we've got a model of care for HIV that works very well, and it includes our coordination between our providers, our clinics, our pharmacies. And frankly, I'm concerned that we're going to see our model imperilled by this behemoth merged organization and the power that it has.

Q. And let me just back up on the clinic. So you say you have roughly 60. Are they served by physicians in those clinics?

A. So we -- our medical providers are a combination of physicians and what are called -- have been called mid-levels, but the preferred term nowadays is advanced practice providers. So those would be nurse practitioners and physician assistants working under supervision of a physician.

Q. And are the providers at these clinics credentialed?

A. Yes. It's a requirement of employment at AHF that any provider who's not credentialed as an HIV specialist at the time of hire has to become credentialed within 12 to 18 months of starting.

Q. What about the pharmacists that are employed at your pharmacies; are they credentialed?

A. Yes. So the American Academy of HIV Medicine also has a credentialing program for pharmacists, and our pharmacists are all credentialed as HIV pharmacy experts.

Q. Now, can you talk a little bit about the health

insurance plans that AHF has.

A. So AHF's own plans you're talking about?

Q. Yes.

A. Okay. So what we have is, in California, Florida, and Georgia, AHF created Medicare managed care plans that are what are called SNPs or special needs plans. They're open only to patients with an HIV diagnosis. Then, in California, in addition, we have a Medicaid managed care plan.

Q. Can you expound a little bit more on what you call the wrap-around services, the continuum of care that AHF provides from the clinics to the pharmacies.

A. So we actually start even earlier with -- than the clinics with this kind of, you know, comprehensive continuum of care. We do more -- AHF does more HIV testing than anyplace else in the world, anyone else in the world. So if somebody tests positive for HIV at one of our testing sites, they immediately become part of our linkage program. A linkage counselor, who is somebody who's trained in HIV and dealing with patients, immediately contacts the patient, serves as support and education. And we have a standard that anybody who tests HIV-positive is seen in one of our clinics within 72 hours of their diagnosis. The linkage person will literally take them by the hand and walk them into the clinic if need be to get them initiated in care.

Once they're in the clinic, we practice

patient-centered, high-touch care. We provide these wrap-around services that, again, most patients who at the time their HIV diagnosis don't have private insurance or any other funding source, so they get an appointment with what's called a benefits coordinator to find out if they qualify for typically the Ryan White Program, which is a payor of last resort for patients with HIV or an ACA plan or a Medicaid plan. And so we get them benefits that way. We have -- because a lot of our patients have a lot of multiple comorbidities and are medically very complicated, we have --

Q. What do you mean by comorbidities?

A. Other medical conditions that are -- not just HIV. You see a higher rate of heart disease, diabetes, kidney disease, liver disease; a lot of different things in patients with HIV.

And so we have medical case managers, who are usually RNs, to help coordinate the care for these patients so that everything is being taken care of.

One of the things -- one of the other things that is unique about AHF is that what we practice is what I call HIV primary care. We discovered that patients just kind of naturally adopt their HIV treater as their PCP or primary care physician. So there's some places where there's someone who manages the HIV using an infectious diseases doctor but won't manage the cholesterol, the blood pressure, won't see

the patient if they've got a cold or the flu. We're the primary care doctors as well as the HIV specialist for our patients.

Q. Can you explain how important it is to make sure that HIV/AIDS patients adhere to their medication schedule. Talk about that.

A. I find frequently nowadays that -- I think people think -- a lot of people think that something has fundamentally changed about HIV as a disease, and it hasn't changed. I mean, untreated, it is still going to kill the vast majority of people who have the virus.

What's changed is that we have medications that can now keep the HIV under control. These medications, though, require a very high level of adherence. We know that, based on studies, that people who take chronic medications for other conditions, like say high blood pressure, that their adherence to the medications is usually 70 to 80 percent. Studies have shown that in HIV if you have less than a 95 percent adherence to the anti-retroviral medications that the virus has the opportunity to activate, mutate, and become resistant to the medications, and then they won't work anymore. So adherence is a huge issue in this disease.

Again, we can't cure it, but if we keep the virus suppressed, not only does the patient stay healthy, but studies have shown the patient cannot transmit HIV to another

person. So there's not just a personal health issue for the infected patient but a major public health issue as well.

Q. You mentioned anti-retrovirals. Can you just explain that.

A. These are the medications that work through various mechanisms to block HIV from replicating and infecting other cells. So these are medications that are used only for HIV treatment. They're often complicated medications with potential side effects and drug interactions with other medications. So when you're talking about anti-retrovirals, you're really talking about the medications used to suppress HIV.

Q. In this model that AHF has to treat HIV and AIDS, does it work?

A. It works incredibly well. The CDC puts out data. There's something called the Gardner Cascade, and it is named after Dr. Gardner, and he did an analysis of the continuum of care starting with how many HIV-infected persons there are in this country to then how many of those people know their HIV diagnosis, how many have engaged in care, how many have been retained in care, and then ultimately how many have their -- and in how many is the virus suppressed, which is the goal. And numbers in the U.S. for that last step of the Cascade show somewhere between 30 and 50 percent of HIV patients in this country being consistently -- with their

virus being consistently suppressed. And at AHF our numbers are closer to 85 percent suppression.

Q. So roughly double the average --

A. Yes.

Q. -- national average?

What are the factors that make for a successful model would you say?

A. I mean, a big part of it is having high touch with the patients. They have actually done studies on retention and care amongst -- with HIV patients -- and have found that the more what they call touch points between the clinic, the staff in the clinic, the physician, you know, so forth, and the patient, the more likely they are to remain in care and remain on their medications. So that's a big part of what we do.

But then we also have very specific things that are very focused on adherence both to the anti-retroviral medications and to medical follow-up. So we have -- the pharmacy generates something called the 35-day report. And if a patient has not been in to pick up their medications within -- in the last 35 days, they track them down. And they find them, and they find out what's going on.

The other thing is that, at AHF, nobody will leave without their medications, no matter what the situation is. It doesn't matter if they can't afford the co-pay. It

doesn't matter if they have lost coverage. We do not let anything interrupt their care.

On the provider side, we have something called a 104-day report, which is similar. But typically, HIV patients come in about every three months for blood work and evaluation by a provider. So if patients haven't been in within 104 days, then every provider every month is given a list of the names of those patients and are expected to personally call those patients and check on them and try to get them back in to be seen.

Q. And how important is it for the physicians to be specialists in HIV and AIDS for the treatment of AIDS?

A. That really is critical. Again, there are studies. Published studies have shown that there's a direct correlation between your risk of death from HIV and the experience of your medical provider. And so we put a big emphasis on making sure that our patients are -- I mean, our providers are credentialed as specialists, that they keep up with education. We have a monthly CME, continuing medical education program, that our providers are -- they're scheduled to block for it every month. It's live webcast to every provider in the country.

Q. And can you talk a little bit about how AHF protects the privacy of your patients.

A. Given that we are an organization that deals with

HIV, we are very, very focused on confidentiality. Though the stigma associated with HIV is much less overall than it used to be when I started in this, there's still a big stigma. Obviously, people want their diagnosis kept very confidential. So when we send out -- we ask every patient when they first come in whether it is okay for us to call them or text them, whether we can send them mail. And we never identify on the mail that it is AIDS Healthcare Foundation. We have -- a lot of our patients who are getting medication through our AHF pharmacies have those medications delivered, and we make sure that our delivery people -- they have IDs, but it doesn't say anything about AHF. To maintain confidentiality, sometimes patients who live with family or roommates don't want meds delivered to the house. The driver will literally meet them at a Starbucks, wherever they want to meet to give them their medication so as to maintain their privacy.

Q. Okay. Now I want to move to just talk a little bit more about AHF's role in the various levels of the market. You identified clinics, pharmacies, and health plans.

A. Uh-huh.

Q. So AHF competes in the pharmacy market with CVS; is that correct?

A. Correct.

Q. And they compete with Aetna as a health plan;

correct?
A. Yes.
Q. And they are a provider, they participate as a provider through the retail clinics; correct?
A. Yes.
Q. And as a pharmacy, AHF is a provider to CVS/Caremark as a PBM; correct?
A. Yes.
Q. You heard the testimony of Dr. Sood about the consolidation generally in the healthcare industry. Do you generally agree with what Dr. Sood said about the consolidation and concentration levels --
A. Yes --
Q. -- in the healthcare industry?
A. -- I do.
Q. Have you seen that even in your 30 years in the business, have you seen those trends of concentration increasing over the years?
A. Definitely. I mean I'm not quite sure how many years ago it was now, but we saw it with United and OptumRx becoming a single conjoined entity. I don't know if that was a merger or purchase or whatever it was. And almost immediately we saw our patients being told that they could no longer use the AHF pharmacy; that they were being forced into mail order programs for their medications. And it was a real

disruption of their continuity of care and emotionally was very difficult for a lot. I had patients in tears about -- our patients, just as they develop a strong relationship with the providers, they develop an equally strong relationship with the pharmacist and the pharmacy staff.

Q. In that instance, what was Optum/United telling these AHF patients in terms of whether they needed -- had to use mail order?

A. So they were being told that they had to start receiving their meds by mail order. And we -- I personally started dealing with numerous problems associated with that. I mean, one of the really frustrating things that I dealt with was -- you know, there would be a screw-up or something wouldn't get processed properly at the PBM, and a patient wouldn't receive his or her HIV medications, and I would get on the phone with the PBM and say, you know, get the problem straightened out. And say, this patient is going to be out of medication tomorrow, you need to overnight this to the patient.

And they would say, no, it takes 10 days.

And I'm like, but this is HIV. You don't understand it. They can't be off their medication for 10 days. That's dangerous. It puts them at risk of developing resistance to their medications.

Well, that's our policy.

You know, it was things like that.

And we had patients who were trying very hard to opt out of the mail order, and we were told at various times that patients had the right to opt out. But whenever they tried to do it, it never seemed to happen. Either they were told that they couldn't opt out despite what we had been told or there were so many barriers to it that it just wouldn't get done. So it was very problematic.

Q. Other than Optum and United, are there other PBMs that require the mail order?

A. Well, increasingly, what we have been seeing is a lack of -- well, what we're seeing is that they're taking away -- pharmacy choices being taken away from patients, and they're being told that they have to use a particular pharmacy or they have to use a particular mail order program. Most of our -- sometimes there is a bit of a financial benefit to patients if they use mail order. Now, some places they'll get three months' worth of medication but only pay two months' worth of co-pays. But almost a hundred percent of our patients were more than willing to pay the additional co-pay in order to stay with our pharmacy and that relationship.

Q. And are there instances where the mail order invades the privacy of the HIV patient?

A. That was another problem that we encountered where medications were just left at a home where there might have been roommates or family members. We had situations where patients reported that the medications were -- because nobody was home that they were delivered to a neighbor and there was a note to pick it up from a neighbor. We had one very tragic situation in Florida where medication was delivered to a home. The family opened up the package, found out that their son was HIV-positive, and threw him out of the house.

Q. Now, if you could explain a little bit more about this increasing concentration in the industry. Are there other effects?

You mentioned the night Optum/United example, which was a integration circumstances. But has the consolidation affected individual pharmacies like AHF and others?

A. It definitely has. You know, these PBMs are -- they seem to increasingly be assessing higher what are called DIR fees, direct and indirect, remuneration fees, with very little transparency as to what were really being assessed. It's clawed back millions of dollars from us, and those are dollars that would normally be used to support our programs and our mission as a safety net provider. I mean 96 cents of every dollar generated in our pharmacy is poured right back into our clinical programs.

So, you know, we're seeing more and more of that to

the point that we're taking a big financial hit. And I'm not an expert on DIR fees, but I just -- some of them are assessed for what the PBM says are AHF not meeting certain quality metrics that, frankly, seem to be arbitrary and capricious. Like, we've had money taken back because certain patients weren't on a Statin, a cholesterol-lowering medication. But there are times that you can't use Statins with HIV medications. There are going to be life-threatening drug interactions. The other thing is I just don't understand how you can hold the pharmacy responsible for something that they can't prescribe medications. That's the physician. Anyway, things like that that are very frustrating.

Q. So these fees are where the PBM is actually clawing back money that had already gone to the pharmacy later?

A. Yes. And I think with AHF it is into the millions. And the thing is that they can claw back way after the adjudication of the claim. They can come back like a year later and ask you for significant sums of money back.

Q. Have you also seen an effect on the reimbursement rates that you're getting from PBMs?

A. The other thing -- I mean, we certainly aren't alone in this -- but some of the -- the reimbursement rates have dropped, and at times to a point where it doesn't even cover the cost of our medication, of the medication that we

purchase. So, obviously, that's another big issue.

Q. And why can't AHF just decide to go to another PBM? What's --

A. So, if you take a plan like our managed Medicare plan, which, like I mentioned, is a special needs plan, it is especially designed for people with HIV, so it's way different from a regular Medicare Advantage plan in that sense. But we still are required by CMS, our managed care plans have to meet certain criteria. And one of them is access to pharmacies where patients can get their prescriptions filled that are within a certain distance and a certain time of travel from the patient. And we're a small network of pharmacies. So to have something that is convenient for our patients that meets CMS requirements, we need to be contracted with a large chain like CVS which has got locations everywhere.

Q. So, basically, you have no choice, is that what you're saying?

A. Yes.

Q. Okay. Can you talk about how PBMs have narrowed networks.

A. So the other thing that PBMs have done is that they've created what are called narrow networks of participating pharmacies so that they may have CVS in there but have hardly anybody else that is allowed to participate,

so excluding independent pharmacies from participating, from being preferred providers under the PBM.

Q. And Dr. Sood, you heard his testimony, he talked about a lack of transparency in the PBM market.

A. Yes.

Q. Is that something that you have found?

A. Yes. Again, I'm not the pharmacy budget expert, but I will tell you from sitting on the pharmacy exec committee and so forth, I mean, one of the frustrations is that there is no transparency. You don't know what deals the PBM has worked out for rebates, and you don't have any clear criteria about how they're assessing these DIR fees. Yeah, it's like a black box that you can't see through.

Q. And there has also been public discussion about how PBM contracts have, quote/unquote, gagged pharmacies.

A. That has certainly been in the news where some of the PBM contracts contain essentially gag orders on their -- say you've got under your plan a co-pay for a medication that is $10 but you're getting a very common generic, and you could get the entire -- you could just pay the cash price and get it for like $2. You know, pharmacists were prevented by several PBMs from informing the patient of that. So, yeah, those -- and you know, in my experience, what the PBMs have done is they have really added a layer of bureaucracy, another layer between provider and patient. And certainly,

from a care side, clinical care side or a patient side, I see zero benefit and only harm, to be honest.

Q. What was the promise of PBMs when they entered the market?

A. I think it was that they were going to reduce prices to patients, to consumers, was one of them. And again, I haven't seen that. I mean, in fact, I have seen -- I had one situation where the PBM moved all of the HIV medications to its highest co-pay tier, a tier of five, and then some of the plans were actually -- that were contracted with the PBM were actually setting the patient responsibility portion to 50 percent of the retail cost of the medication. I had a patient who called me up in tears because he went to pick up his medication and suddenly they were telling him it was $900 a month, which was half the retail cost.

Q. Now, there has also been public discussion of what they call squeeze-and-buy strategies by PBMs. Can you tell the Court what that's about.

A. So my understanding is that PBMs either, you know, through DIR fees and/or lowered reimbursements, that they squeeze an independent pharmacy, smaller pharmacy chain to a point that it is no longer economically viable for them to continue to operate, and then they kind of buy them out at pennies on the dollar. There was just an article the other day I read about it with a pharmacy or pharmacy group called

Premier Specialty Pharmacy, I think, and they basically said in this article, we can no longer be viable with what's happened to our reimbursements.

Q. Who did Premier sell out to?

A. CVS.

Q. I want to talk about the effects of the merger.

So do you have any concerns? I mean, you said initially you were concerned about the merger and that's why you're here. Can you tell the Court what specifically your concerns are with respect to the merger as it is currently constituted?

A. You know, my concern is that AHF, our pharmacies will be squeezed the way these others have; that either they won't be preferred pharmacies for patients under their insurance or they'll be excluded completely from using the AHF pharmacy. I'm concerned that it really cuts into these decreases in reimbursement and this clawback of fees.

THE COURT: Doctor, let me ask you a question about that.

THE WITNESS: Sure.

THE COURT: Who is it that sets these kinds of requirements? Is it the insurance plan or the PBM that's requiring --

THE WITNESS: So --

THE COURT: First of all, defining something as the

preferred source of the drugs.

THE WITNESS: Uh-huh.

THE COURT: And secondly, where they can get the drugs other than your pharmacy.

THE WITNESS: Right. And I believe that -- if I'm wrong, please somebody correct me -- but I believe that really is set by the PBM, to a large extent. I guess by the -- I'm not exactly -- what role the insurer has, but I believe it is mostly the PBMs that set up the networks of participating pharmacies and so forth, and make these decisions about co-pays and what patients are going to have to pay and where they can access their -- and how they can access their medications.

THE COURT: Say your pharmacies aren't designated as preferred providers, then they have to go to -- do they list who the preferred providers are?

THE WITNESS: Yes. I mean, they usually will. I mean, so it may not completely bar a patient from going to a nonpreferred provider, but there's lots of economic disincentives to do that.

THE COURT: So the co-pay will be a lot higher --

THE WITNESS: Exactly.

THE COURT: They'll charge much more for the drug --

THE WITNESS: Correct.

THE COURT: So you have seen that firsthand?

THE WITNESS: Yes.

You know, I think that a lot of people don't realize that there is, and should be, a relationship between -- in people with chronic illnesses, serious chronic illnesses -- that there is, and should be, a relationship between the pharmacist and the patient. And I think we've demonstrated at AHF how important that relationship is.

I mean, very frequently I find out for the first time that a patient is having side effects or problems with medication, not from the patient telling me, but the patient has told the pharmacist, who then tells me. Then the pharmacist and I work together to resolve the problem.

And in a condition like HIV, the pharmacist is really important in educating the patient about the importance of adherence.

And one of the other things with PBMs is that when you call a PBM, you have no idea who you're going to speak to. There is no ongoing relationship. I've had situations where I've spoken to a pharmacist, and they can't even pronounce the names of the drugs I'm talking about. They have no experience with HIV medications. And it is very much kind of a -- it is like calling customer service a lot of places, and you get caught in voice mail hell.

THE COURT: Okay.

BY MR. BARLOW:

Q. Is it your concern that the merger will affect how Aetna's patient population will be directed to certain pharmacies?

A. Well, I mean, I would think that is likely to happen and certainly is a concern. Anything that is going to pull patients out of our pharmacy, where they've got specially educated pharmacists and staff, they've got a very close personal relationship, it's -- we have -- in every one of our clinics we start the day with what is called a morning huddle where we discuss all of the patients coming in that day. And the pharmacist is part of that morning huddle. I mean that's how integrated they are into our care model.

Q. And so what happens if all of the Aetna patients are directed to CVS pharmacies and away from specialty providers like AHF? What is the practical effect of that?

A. So, you know, I think that you're going to see more patients getting sick, frankly. I mean, again, you can't walk out of a CVS if you don't have your co-pay. And we especially seek out -- seek to place clinics in places where patients don't have great access to care, where they're economically disadvantaged, and so forth. But we make sure that they always get their meds; that if there's a co-pay, it is always the lowest tier co-pay; that they've got access all the time to pharmacists for education.

I also know that CVS isn't going to have a 35-day

report and call patients to ask why they haven't been in to pick up their medications.

The other thing that I might mention is that increasingly insurers are requiring what are called prior authorizations for medications. So, in other words, before they will cover a medication, you have to do a prior authorization, which often involves doing this whole medical justification. And you'll find doctors nowadays who really are -- you know, take the attitude this isn't really my problem. You know, I ordered the medication. This is what I thought you needed. Take it up with your insurance company if they don't want to pay it.

But what we do at AHF, and really headed by the pharmacist, is that we aggressively work to get that prior authorization approved. So we act as an advocate for the patient, as well.

Q. Is there also a concern of the merger that Aetna patients going to MinuteClinics? Is that something that you're concerned about?

A. You know, I have read that part of this integrated care concept with this merger is that now you've got all of these clinics around the company that are now going to be part of the patient's care network. Look, I think a MinuteClinic is fine if you need a particular vaccine or if you have got a cold or something like that. I think it would

be a disaster if HIV patients were encouraged to seek medical care at a MinuteClinic. I can, again, tell you that HIV is a highly specialized -- I think this is true for any chronic illness. I don't know that HIV is unique in this sense. But you know, what you're going to get is fragmented care by people who don't understand the disease and who don't understand the risks of drug interactions, adherence, side effects, all that kind of stuff.

Q. Let's take as an example a flu shot?

A. I'm sorry?

Q. A flu shot.

What is the effect of an HIV/AIDS patient getting a flu shot at a MinuteClinic?

A. There are certain types of flu shots that HIV patients are not supposed to receive because of weakened immune system. There are certain types of -- as a general rule, live-virus vaccines are usually not given to HIV patients because their weaknesses in their immune system could create particular side effects. We are very aware of those kinds of issues. I highly doubt that a MinuteClinic is -- you know, they probably have whatever flu shot they're giving, and I kind of doubt that they would be aware that there are certain types that should not be given to patients with HIV.

Q. In terms of privacy, you spoke about that earlier,

are you aware of instances where both CVS and Aetna have been sued for violating privacy of HIV patients?

A. I know they have both been sued over separate instances of revealing patients' HIV status.

Q. Now, you heard Dr. Sood testify about what he called about input foreclosure. Do you remember his testimony there?

A. Yes.

Q. The idea being that there's a risk after the merger that there will be a degradation of care, so to speak, from the pharmacy, or the PBM level down to the health plan level. Is that something you're concerned about?

A. Yes. I mean, for all the reasons I have already mentioned, it is a very different setup than what our pharmacies have.

Q. Well, for instance, what if one of your managed care plan patients was forced out of that plan into say an Aetna Medicare Advantage plan? What would be the effect of that?

A. Well, first, the biggest impact is that these Medicare Advantage plans are not special needs plans. By virtue of the fact that we have a designation that our plans are designated as SNPs or special need plans, you know, patients actually are not limited to the enrollment period with Medicaid Advantage. They can come on and off our plan as needed. Our co-pays for HIV medications are set at the

lowest-tier co-pay. There's -- they go from -- they could be assigned to a PCP who was just most likely a general internist or family practitioner who probably knows little to nothing about HIV treatment. A lot of concerns.

Q. And that could happen if post-merger the CVS pharmacy services were denied to a health plan participant?

A. Yes. I mean, I don't know that under CMS rules that we can meet CMS -- our plans can meet CMS rules if we aren't contracted with somebody like a CVS.

THE COURT: Can you give me some idea, Doctor, of one of your chronic patients who has HIV and is on this regimen of multiple medications --

THE WITNESS: Yes.

THE COURT: -- what would the monthly charge for medication be to him in terms of his co-pay and in terms of the insurer --

THE WITNESS: Right.

THE COURT: -- the retail amount --

THE WITNESS: So I would say that --

THE COURT: -- roughly.

THE WITNESS: -- a regimen would run somewhere between $1,500 and $3,000 a month in terms of the cost of the medication.

THE COURT: That is retail? Or wholesale?

THE WITNESS: That's what -- if a patient came in and

needed to buy it cash, that's what they would pay.

THE COURT: Okay.

THE WITNESS: And the co-pays vary a lot based on the patient's plan. But I'm pretty certain that all insurance companies, other than AHF, have HIV medications on the higher-tier co-pays, which mean higher out-of-pocket cost. In fact, with that patient I mentioned who suddenly -- he went up to a tier where he was responsible for 50 percent of the retail cost of the medication, you know, I had conversations with the PBM, and they were very surprisingly honest with me and said: We want to put these meds on a higher tier because we don't want anything that is going to actually encourage HIV patients to choose our plan. We don't want to make it appealing to them because they're high-cost patients.

THE COURT: So what would the lowest co-pay be, how much a month, roughly? 500?

THE WITNESS: No, it probably is less -- again -- so you've got some patients who are on plans that they have a set co-pay amount. So it could be $50 or $75 or something like that. This was a particularly unusual setup, yeah, yeah.

THE COURT: You've got about five minutes left.

MR. BARLOW: Okay.

BY MR. BARLOW:

Q. Just to wrap up, you've heard the benefits of the merger that have been put forth by the parties. One of them that's been talked about is that the merger will lead to increased compliance with treatment plans, medication therapy management.

Do you have any reaction to that claim?

A. I don't see that. I honestly can't even conceive of how that would be improved. It just seems that there would be fragmentation of care.

Q. Have you reviewed the DOJ's proposed Final Judgment?

A. I did read it, yes.

Q. In your view, is the approval of the proposed Final Judgment in the public's interest?

A. Personally, I don't think so because it doesn't address these particular issues. And I'm afraid that without addressing them that we will end up with a very uneven, unfair playing field that will make it hard for AHF to compete. I think that, you know, given a level playing field, I think that we can compete, because based on our care model and our personal service, and you know, I think patients choose to stay with us, to use our plan, but I'm worried that that won't be enough because it won't be an even playing field.

Q. Would there be an alternative to approval of the judgment that in your judgment would alleviate your concerns?

A. It would be great to see if there were guarantees of, you know, pharmacy choice and that patients and -- and also that our plans would continue to be able to participate as preferred providers in the -- like, in the CVS pharmacy network. But I would feel a lot more comfortable if there were language that did that.

MR. BARLOW: That's all I have, Your Honor.

Thank you.

THE COURT: Let me ask one last question. The insurance programs that you offer as part of your services --

THE WITNESS: Yes.

THE COURT: -- those, like your institute itself, is a not-for-profit; is that correct?

THE WITNESS: That is correct.

THE COURT: So the profit incentive or motive that other companies that offer insurance programs --

THE WITNESS: Right.

THE COURT: -- is not present in yours?

THE WITNESS: That's correct. Yeah.

THE COURT: Very good.

Thank you, Doctor. You can step down.

THE WITNESS: You're welcome.

THE COURT: We will take a 15-minute recess, and then we'll hear the final witness for today when we return.

So we stand in recess.

(Recess taken)

THE COURT: Call your witness.

MR. BALTO: Your Honor, David Balto on behalf of Consumer Action United States Public Interest Research Group, we call Dr. Diana Moss as a witness.

THE COURT: All right. Come up and be sworn.

DIANA L. MOSS,

having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. BALTO:

Q. Dr. Moss, please state your name and spell it for the Court.

A. My name is Diana L. Moss, D-I-A-N-A, L, M-O-S-S.

Q. Diana Moss, can you please give the Court an overview of your testimony for today.

A. Yes. My testimony today will cover two basic themes. One is comments and observations on the horizontal aspects of this proposed merger between CVS and Aetna and the consolidation in the standalone PDP markets and the proposed remedy and whether we think that remedy will likely be effective in preserving competition. And then the second part of my comments will address very serious competitive concerns that were not addressed by the government, and that includes two forms of vertical foreclosure and their effects

on competition and consumers.

Q. Dr. Moss, can you please introduce yourself to the Judge and give him a bit of your biographical background, including on merger divestitures.

A. Certainly. I am the president of the American Antitrust Institute. We have been around for about 20 years, a progressive think tank advocating for competition that protects consumers and businesses in society. We do that through legal, economic, and policy work in the form of research, education, and advocacy.

I am a Ph.D. economist, and have worked in the area of industrial organization for almost all of my career in a number of sectors, including healthcare.

AAI has been very active in the healthcare area. We have filed a number of letters to the agencies, the FTC, DOJ, the states, white papers, letters. We have testified in front of Congress, in front of various commissions on the competitive and consumer effects of healthcare consolidation.

Most recently, I have turned my research to remedies in merger cases and have co-published an article with John Kwoka -- Professor Kwoka is at Northeastern University -- on issues and problems that we have identified with different types of merger remedies, including conduct remedies versus structural remedies, and recently had a piece out in *Global Competition Review* in their *Guide to Merger Remedies*.

Q. Thank you.

By the way, you have been a public servant in the past; isn't that correct?

A. I have been a public servant. I was at the Federal Energy Regulatory Commission for about six years, where I coordinated the Commission staff work on electricity mergers.

Q. Dr. Moss, please tell the Judge about AAI's healthcare competition expertise.

A. So, as I said just a minute ago, we have a diverse array of resources through our advisory boards, through our staff expertise, with expertise in law, economics, institutional issues, and public policy. And much of that has focused on a variety of industries, including healthcare, where we have been very active in promoting competition and vigorous review by the federal and the state -- federal agencies and the states to look at these mergers in healthcare at all levels of the supply chain because we have really grave concerns about their effects on competition and on consumers and workers.

Q. What is the specific advocacy that AAI did on CVS-Aetna?

A. So we submitted a letter back in March of 2018 to the U.S. Department of Justice, Antitrust Division, unpacking the vertical aspects of the CVS-Aetna merger. We also filed Tunney Acts in December of 2018 in this Tunney Act

proceeding.

Q. Can you give the Judge a brief picture of the kind of healthcare advocacy AAI does; studies, reports, things like that?

A. So our analyses are fairly deep dives into legal, economic, policy, and institutional analysis. We take weeks, if not months, to produce a white paper, which is typically a heftier, beefier analysis. And we do that on a regular basis. We choose our cases very carefully, cases that we believe raise really seminal issues of law or policy or economics.

And I'm not shy about saying that I think that AAI's work is generally regarded as independent and objective and very high quality.

Q. Dr. Moss, have courts relied on AAI's advocacy in the past?

A. I believe that to be true. And we have been cited by courts in a number of areas, including our amicus briefs, our white papers, and letters in a variety of cases. Most recently cited or referred to as a titan in the antitrust arena, something that we were very gratified to hear.

Q. Thank you.

Dr. Moss, given your expertise in antitrust and healthcare, what are the important lessons for the Court today from what you have heard from Dr. Sood and

Dr. Wohlfeiler's testimony?

A. So I think there are three major takeaways or observations so far that I would like to offer to the Court about this particular merger and consolidation in healthcare more generally.

I would like to emphasize that we are really at an inflection point in consolidation in the healthcare industries. There has been sweeping and massive consolidation in all levels of the healthcare supply chain; in hospitals, in pharmacy benefit manager markets, in retail pharmacy markets, in health insurance. What we have moved from is pretty vigorous competition by standalone rivals at each level in the supply chain. We have moved from that model of well-ventilated, competitive markets where rivalry produces the low prices and the high quality and innovation for consumers. We've moved from that to a system where we now have vertically integrated platforms of insurers and pharmacy benefit managers and pharmacies. For example, Express Scripts-Cigna just went through. We have UnitedHealthcare and Optimum as a vertically integrated insurer and PBM. We now have CVS-Aetna on the table as yet another vertically integrated entity. I have seen mention in the press of Centene and WellCare merging in another vertical combination.

So what this does is it fundamentally changes the

structure of the industry, and it changes the incentives and the abilities of these firms to compete hard on price and quality, because through vertical integration, they have incentives, much of which we have heard about today from Dr. Sood, incentives to foreclose their rivals or to make it difficult for their rivals to compete. So having a bunch of vertically integrated firms -- and it is not even a bunch, it is just going to be a few when this is all over -- unfortunately have very conflicted incentives to promote competition, to serve and deal with their rivals at arm's length, and that raises serious issues for consumers and competition.

The second point I would like to make is that this is really a very high-stakes game. Not only are consumers implicated by the CVS-Aetna merger, but taxpayers are implicated through the Medicare Part D and low-income subsidy program. We have high-risk individuals, as we just heard from the previous witness, who are potentially in danger. And these are important parts of consumers' pocketbooks. Insurance premiums are an enormous part of a pocketbook or family spending. Drugs costs are an enormous part of spending for healthcare providers. And I believe drug costs are approaching about 20 percent of total healthcare expenses.

We also have a quality issues. This is not just

about price and higher premiums and higher drug prices and costs, but it is about quality. It is about disease prevention. It is about keeping mortality rates down. It is about innovation, innovating new technologies, new drugs, new business models to serve competition and consumers.

So I just want to emphasize the price and the non-price dimensions.

Finally, the third point or takeaway, and Dr. Sood spoke to this really terrifically well, is high concentration in markets should be given a significant amount of weight. And it is a strong -- creates a strong presumption of illegality under Section 7, which is an incipiency doctrine, as we know. And the reason why concentration is so important here is in regard to consolidation in these PDP markets and the requirements that creates for a very effective remedy to ameliorate those concerns.

But when we turn to the vertical issues, it is also extremely important to realize that high concentration in PBM and pharmacy markets and also in health insurer markets really limits choices for consumers to switch away from a company that might be engaging in anticompetitive conduct.

So we don't need a lot of rocket science and bargaining theory. This is pretty simple stuff. When you have markets that only contain two or three dominant firms, rivals, that really limits the ability for consumers to

switch, or any other participant in the market to switch away from a firm that is vertically integrating or horizontally integrating.

Q. Dr. Moss, let's spend a moment on that difficulty of switching. So let's say that tomorrow there is a new policy suggested, like Dr. Wohlfeiler suggested. Why can't a consumer just sort of pick things up and move from one insurance plan to another plan?

A. Well, the most obvious reason is because they're aren't many options. Right? If you can't deal with CVS, which is essentially a "must have" pharmacy network for many insurers and there are very few options to turn to, then that limits the opportunities.

Secondly, there is in many cases brand name loyalty that creates a lock-in effect for some consumers, health insurers, for example, in preventing switching. But, fundamentally, when you have very few rivals in a market, economic theory and evidence shows that higher levels of concentration contribute to either following behavior by firms or coordination between firms, which results in higher prices and lower quality.

So consumers are really disadvantaged by tight oligopoly markets where you just have a few rivals.

Q. Dr. Moss, let's focus on the PDP market. Why is concentration so crucial in this market?

A. So in the PDP market, I would note that the government, in its complaint -- I'm sorry -- the competitive impact statement actually led with the statement that competition is critically important in these PDP markets. They say Congress designed the Medicare Part D program to rely on competition --

THE COURT: Slow down.

THE WITNESS: -- among multiple plan sponsors.

Sorry.

PDPs are really, really increasingly important to consumers. There's been 6 percent year-over-year growth in Medicare Part D enrollments from 2006 to the present. There's been an 18 to 30 percent growth in Medicare's share of U.S. retail prescription drugs spent between about the same period of time. So the Medicare Part D PDP plans are increasingly important to consumers, particularly seniors, low-income consumers, at risk-types of market participants.

We're concerned that average monthly premiums have escalated rapidly, especially since 2015. There's been an 11 percent increase in premiums for standalone PPDs, and a 53 percent increase in premiums for low-income-subsidy enrollees. Those are really, really significant increases in premiums for populations, consumer populations, that are at risk.

The other reason why concentration is so critically

important is because when you have a market that is dominated by entrenched large firms and a very small fringe of tiny firms, much like we see in the PDP markets, then it is really hard for those smaller firms to inject any competitive discipline in the market. They need access to financial resources. They have to engage in multi-year planning. They need scale. They need personnel. They have to contract with pharmacies and other providers.

So, unfortunately, with highly concentrated markets, as we see in insurance and in pharmacy and PBMs, we just don't have smaller firms that have the heft and the ability to inject competitive discipline.

Q. What are the obstacles for those smaller firms to effectively expand in the PDP market?

A. I think they're very limited. And we have seen failures of smaller firms to be able to enter. In the case of the CVS-Aetna merger and the Express Scripts-Cigna merger, where we are seeing more and more vertically integrated platforms, that will raise entry barriers significantly because firms can't enter at just one level anymore. So a firm can't have an innovative online pharmacy model and really effectively enter without having integration into a base of insurance customers, for example.

So all of this consolidation in the industry, including this merger, has really raised barriers to entry

for smaller market participants.

Q. Do those factors lead to further consolidation? Do they in effect force firms to consolidate recognizing that they can't expand?

A. Yes. I think that firms in a market where you have just a few entrenched dominant firms and a very small fringe of struggling rivals, I think it creates a scenario where small firms are more easily picked off by the larger firms, which creates yet another wave or another cycle of consolidation.

Q. Let's talk about how highly concentrated the market is if this acquisition is consummated.

A. So we're talking about PDPs, PDP markets. So Dr. Sood I think has done a really terrific job of highlighting the high levels of market concentration in multiple regions under the PDP plans.

I believe the DOJ's complaint states that 12 Part D regions, which is about 75 percent of the relevant geographic markets, will result in large increases in concentration. CVS-Aetna would account for more than 35 percent of the low-income-subsidy-eligible beneficiaries in an additional nine regions.

So, clearly, the merger results in anti- -- will likely result in anti-competitive effects and anti-consumer effects in these PDP markets, and is really presumed to

enhance the market power. So that's where this strong presumption of illegality or the structural presumption of illegality comes in here.

Q. Let's spend a few minutes, Dr. Moss, talking about whether the effects from increased concentration or other forms of anti-competitive harm. We've talked a bit about price. I presume the witnesses tomorrow will say there is no price effect.

What is your response to that?

A. Well, I think all of the empirical evidence that Dr. Soot has cited and that I have certainly seen is that premiums will increase as a result of consolidation. And quality may well go down as a result. There may be -- there may be a degradation in coverage. There may be a degradation in terms of the drugs that are offered in the plans. There may be fewer incentives, for example, to protect consumers', subscribers' privacy. That is a sort of a quality competition issue. And certainly much less pressure to innovate in terms of providing better service, new products, faster to market.

So I think both the price and the non-price effects from a highly concentrated merger like this in the PDP markets is really a very serious concern.

THE COURT: The non-price effects include availability of drugs, more readily available?

THE WITNESS: Absolutely, yes.

THE COURT: So putting price aside, which is obviously one barometer of evaluating whether it is in the public interest or not --

THE WITNESS: Yes.

THE COURT: -- availability or lack of availability to drugs --

THE WITNESS: Right.

THE COURT: -- what would be probably next most important after that in the non-price?

THE WITNESS: From a non-price effect?

So availability of the drugs. Is the coverage in terms of the portfolio or the formulary appropriate for the subscribers? Are there drugs that are in demand? I think there are fewer incentives with less competition to innovate on newer, better business models or delivery systems for drugs to really bear down on efficient contracting practices with drug companies and other members of the supply chain.

So the non-quality aspects of competition I think are really, really as critical as the price effects of competition.

BY MR. BALTO:

Q. Let's go back -- just to fully inform the Court, let's go back to Dr. Wohlfeiler's testimony and recall what he testified about, about the relationship between the

pharmacist and the patient, the advice that they receive, or the concerns about privacy.

Are those kinds of concerns cognizable? Are those the kinds of concerns that the Court should look at?

A. I believe the Court should legitimately look at those concerns.

What we have found through research is a record of, for example, independent pharmacies having a much harder time competing as a result of practices by PBMs in a highly concentrated market. And consumers have lost, for example, access to independent pharmacies that offer counseling services for risk of heart disease and diabetes. And those types of services may well disappear as a result of the integration that we're seeing here.

Q. So something like AHF's offering drugs no matter what the coverage is or providing the 35-day call, the loss of services like those would be cognizable?

A. Absolutely.

Q. Okay. Well, we're here today to talk about whether or not this is an effective merger remedy.

Dr. Moss, first of all, give the Judge your perspective generally, looking at hundreds of merger remedies, about what it is the agencies and courts are supposed to do and whether or not that effectively works.

A. The agency's own guidelines state that a merger

remedy should fully restore competition lost by the merger. Another way of saying that is that the remedy must preserve competition, essentially as if the merger had never occurred.

So that's what an effective remedy essentially is, is one that fully restores competition lost by the merger. An effective remedy should really align with a magnitude of competitive and consumer harm. Right? So the more serious the concern, as we see here in the PDP markets with the effect of this merger, really is a heavy lift on crafting a remedy that is going to fully restore competition.

And I would note for the record that sometimes the most effective remedy is for the government to move to block the merger, in fact. And we have seen that. We saw that in previous insurance mergers, in Anthem-Cigna and also in Aetna-Humana where both mergers were essentially denied because they were concentrative and would have created significant harms.

In AIA's 20 years of research and advocacy, we have seen a growing list of a number of failed remedies. And this remedy, the PDP remedy here, concerns us because it bears a lot of resemblance to some of these other cases. For example, in the healthcare space, UnitedHealth and Sierra merged, Aetna and Prudential merged, and Humana and Arcadian merged. These all occurred within the last, say, 10 or 15 years.

So in the first two of those cases, UnitedHealth-Sierra, Aetna-Prudential, after a divestiture, it was documented empirically that rates went up, that premiums went up. So that would not be an effective remedy if the divestiture were put into place and then prices went up afterward.

In Humana-Arcadian, WellCare had assumed those assets in several counties in Arizona and then two years later exited the market. That would not be an effective divestiture because the buyer was unable to maintain or reinject competition.

We have seen failed remedies in Safeway-Albertsons, in Dollar Tree-Family Dollar, in Hertz-Dollar-Thrifty, all buyers who were unable to maintain the assets who could not step into the shoes of the merging party that divested the assets. So all of this means that a remedy was ineffective and that the harmful effects of the merger actually did occur because the remedy was not successful. And we have very similar concerns in this case.

Q. So the last time WellCare had a divestiture, it struck out?

A. In the Humana-Arcadian merger, that is correct.

Q. Is part of what the agencies -- how do the incentives and abilities of the firm that is acquiring the assets, how is that included in the analysis?

A. So to fully restore competition or step right into the shoes of the market participant from which the assets are being purchased really requires a lot of things to fall into place pretty quickly and successfully.

So there are really three major observations about why that is likely not to be the case in CVS-Aetna in PDP markets.

One is simply the highly concentrated nature of the PDP market. And we heard this, of course, from Dr. Sood. But the punch line up front is that because of high concentration and just having a few firms in this market, United and Humana and CVS, I believe Express Scripts is in there a little bit, WellCare post-divestiture would have a 13 percent market share, but because they're aren't any smaller firms and because WellCare was really on the fringe of even being a good candidate, you really don't have many possibilities as buyers of divested assets to reinject that competition.

Q. So you're saying this is basically a very tough market to enter into even if you're given that boost of the additional Aetna lives?

A. Absolutely.

And so there are several concerns as a second point about WellCare Health not being well positioned to successfully compete after it assumes the assets. It is much

smaller relative to Aetna. It is about a quarter of the size in terms of enrollees. It lacks the economies of scale and scope and the brand reputation that Aetna has. We've talked about that.

Also of concern is the fact that when WellCare Health assumes Aetna's PDP enrollees, they will need to absorb about 180 percent increase in enrollees in a really short period of time. That's an enormous uptick in the number of enrollees.

We also know that WellCare Health has struggled a bit between 2014 and 2017. They lost on average annually about 4.6 percent of their enrollees in these PDP plans that they have.

And as I just mentioned, they exited the market very shortly after buying assets in the Humana-Arcadian merger.

Q. In determining whether a firm has the ability to effectively restore competition, which you said earlier is fully restore competition, how crucial are these elements, the past history and the perspective of how much it has to --

A. Oh, I think they absolutely bear serious consideration in determining whether WellCare Health is a viable buyer of the assets and whether they are going to be able to reinject the competition.

To be honest, the way the consent -- the remedy is structured in the consent decree raises additional concerns.

It is a very limited set of assets. It is sort of riding on the border of being a divestiture of an ongoing business versus just a bundle of selected assets, which the FTC has had a lot to say about in examining its own divestitures. Brand loyalty could well limit WellCare's ability to attract customers later on. It puts enormous pressure on WellCare Health to quickly step in. The administrative services agreement that's part of the remedy expires at the end of this year. And Aetna can start re-marketing products under its own brand name and the CVS brand name in less than two years. Okay?

Aetna employees are not being transferred with the contracts, the PDP contracts.

So if you take all of these factors together, you have a track record and you have a remedy and you have a market, and critical attributes of the market in terms of high concentration that really call into question the efficacy of this remedy in addressing the very serious harms that are identified in the complaint.

Q. Dr. Moss, let's spend a little time unpacking some of this for the Court.

The administrative services agreement expires in 2019. Why is that important to WellCare in being able to effectively enter the market and fully restore competition?

A. So, in many divestitures, there will be the actual

divestiture of the asset itself, although in this case this isn't a manufacturing facility. It is a collection of contracts. But other things need to go with it. There needs to be support. There needs to be transfer of information and records. There needs to be ability for the buyer to tap into the expertise and the advice of the original owner of the assets. So this collection of support in terms of access to the contracts and ability to use the brand name of Aetna for a year -- I believe it's a year -- those are all sort of ancillary but vitally important to supporting the actual divestiture of the assets itself.

And that, as I said, is only in place for about seven more months.

So WellCare will have to really hit the ground running fast and scale up fast and assume an enormous inflow of enrollees to be able to reinject this competition.

THE COURT: Do you have any idea what percentage of CVS's business is devoted to the PDP program?

THE WITNESS: You mean in terms of their overall, for example, overall revenues?

Your Honor, I do not have that number.

THE COURT: Do you know, would it be lesser or greater than the other non-PDP services that it provides?

THE WITNESS: In terms of CVS's business?

THE COURT: Uh-huh.

THE WITNESS: I could guess, but I'm reluctant to guess.

THE COURT: I don't want you to guess.

What, if any, significance do you view the apparent -- I think, if I understood Dr. Sood earlier today, the apparent strengthening of CVS's PBM services ability as a result of this merger as it relates to its other businesses?

THE WITNESS: Sure, sure. So CVS can continue to -- can continue to aggressively expand its PDP plans. Aetna can essentially reenter the market after a relatively short period of time. I think are big incentives, strong incentives for them to continue to do that.

If you take those parameters that have been crafted around the remedy in the consent order and you superimpose that dynamic onto the vertical integration that we see by pairing up a retail pharmacy and PBM with a health insurer, I think you have a rather toxic set of incentives or changed incentives and abilities to potentially make it difficult for rival health insurers to compete or rival pharmacies to compete.

So I think the combination of the horizontal integration in the PDP market and the ineffectiveness of the remedy and the vertical integration will significantly change incentives in ways that may be hard to predict but almost certainly will be harmful to competition and to consumers.

And I don't mean hard to predict in that we can't talk about what they are likely to be, but hard to predict in the sense that you're now dealing with a very complex, even more complex integrated business ecosystem where CVS and Aetna, with their affiliates in multiple businesses, will be leveraging across all of those different businesses in the post-merger, post-divestiture world.

BY MR. BALTO:

Q. In other words, CVS having control of a PBM and control of "must have" retail pharmacies can use that leverage to forestall competition in other areas?

A. Right. Yes, I think it goes without saying that the CVS brand and retail pharmacy and certainly PBM is viewed by rival insurers as being a "must have" input. A much, much stronger case than I think the case in the last big vertical merger, AT&T-Time Warner --

THE COURT: We heard about "must have" TV in that one. It didn't turn out to be as "must have" as some people thought.

THE WITNESS: I agree with you.

I would argue in this case this is a much stronger case for why input foreclosure could be very damaging and why these CVS pharmacy networks really are essential for rivals to compete.

BY MR. BALTO:

Q. Let's go back to drugs. So the point about brands, why is brand really important and the fact that they only have the brand for a short period of time and that CVS can reuse the Aetna brand --

A. Well, a lot of economic research has been done on the role of brand loyalty in shaping demand, controlling demand, if you will. We know that brand loyalty creates what we call lock-in effects where it really limits consumers' willingness to switch to rivals, rival providers. I think in the healthcare industry brand loyalty is very, very significant. You're talking about people's healthcare, you're talking about access to drugs.

THE COURT: Are you talking across the board or in the PDP in particular?

THE WITNESS: I think across the board.

For example, this is my prescription drug card, and it is stamped in red with "CVS/Caremark" across the top. It is in the largest font on the card. And that indicates a significant recognition by the companies that their brand carries a lot of weight.

So an unwillingness of consumers to venture out to switch to a lesser known provider, for example, WellCare Health, would be a pretty significant consideration.

And if WellCare only has the ability to market under Aetna's brand for a year and then in less than two years

Aetna can reenter and start marketing again under their own name, that doesn't give WellCare Health very much time to do anything in terms of injecting competition into the market.

THE COURT: So do you agree with Dr. Sood that they're likely to believe as of now that they're not going to retain a high percentage of the customers that they have acquired?

THE WITNESS: I do. I think that's a really important analysis that Dr. Sood did, the retention analysis. And I think it is spot on, and it is very important to consider that. It will very likely not be a hundred percent retention rate.

BY MR. BALTO:

Q. Dr. Moss, you mentioned before that one of the alternatives would be simply to block the merger. A couple of years ago that happened in the Aetna-Humana merger. Judge Bates, evaluating the remedy in that merger, rejected it. How does the proposed remedy in that merger compare to the proposed remedy here?

A. So I think that there is a stark contrast between the two. Here you're talking about 2.1 million enrollees being assumed by WellCare Health. That, again, is 180 percent increase in what WellCare will have to absorb into its business very quickly.

In the Aetna-Humana case, the proposed divestiture of

almost 300,000 lives, covered lives, to Molina, the court concluded that it would not effectively restore competition. That is a mere fraction of the size of a divestiture as compared to the one that is being proposed here, and that was rejected, not only by the government, but by the Court, as well, in the Aetna-Humana merger, which was the number one reason why the merger was challenged and effectively blocked.

Q. Is there anything that has happened recently that perhaps raises your -- even beyond what you have testified so far that raises your concerns like any proposed acquisitions?

A. Sure. So it is in the news, only in the news that Centene will be acquiring WellCare Health or could -- is proposed to acquire WellCare Health. So a couple of things on that. One is it will create yet another vertically integrated insurer and PBM and integrated company. But for the purposes of the remedy, it is very troubling to hear the news that WellCare, so shortly after acquiring the assets, the PDP assets from Aetna, would be absorbed yet into another integrated healthcare organization. And the reason why that's concerning for the remedy is because that would be a very different animal than WellCare is right now. WellCare right now looks very differently than it would if it were merged into Centene. It would be a much larger integrated organization. It would have fundamentally different incentives and abilities to use those PDP assets to maintain

them or not to maintain them than the WellCare Health that we see today that is the proposed buyer of the PDP assets.

So having a big vertical merger quickly on the tails of this proposed divestiture I think changes the landscape fundamentally because you have very different incentives in that larger integrated organization and how those PDP assets would be maintained.

Q. Okay. Is there anything else you want to say about the divestiture?

A. That's all I have.

Q. Okay. Great.

Let's move on to vertical concerns. Can you give the Court a sense -- I think you already have -- about why there are concerns from vertical acquisitions in healthcare and then what are those concrete concerns in this market.

A. So I would observe that there are four major concerns surrounding vertical mergers and how they can affect competition and consumers. One is through the standard foreclosure theories, right, where you pair up an input supplier with a distributor or a manufacturer with a distributor. Now that firms are vertically integrated, they have assets that give them leverage or bargaining power over their rivals in two levels of market, an upstream market and down stream market. In this case, in CVS-Aetna, the potential foreclosure concerns are not only input

foreclosure, which would be potentially raising the costs or cutting off rival insurers' access to "must have" CVS pharmacies and PBM services, but also what we call customer foreclosure, which would essentially be denying rival pharmacies and PBMs the ability to get at Aetna as a potential customer. So the two foreclosure theories, as you know.

The second concern with vertical mergers is -- I've already alluded to -- is the creation of much higher barriers to entry, where with a bunch of vertically integrated firms, very difficult for any firm to enter at a single level. They have got to come in at multiple levels. And that really just -- scaling that wall would be very, very difficult.

Vertical mergers can also facilitate coordination amongst firms through information exchange between the upstream and the downstream affiliates, which I think we've heard about in some other vertical mergers. And then, of course, vertical mergers can eliminate potential competitors.

The concerns of the consumer groups here in this particular case fall most squarely on the foreclosure concerns, input foreclosure first and customer foreclosure.

Q. From the perspective of insurers, I gather so part of this is CVS will deny access to its pharmacies and it will screw up access to Caremark. So from the insurer's perspective, how crucial is access to an effective PBM?

A. So I think it is well recognized that from an insurer's standpoint that having access to the depth and the scope of the CVS pharmacy and PBM networks is really essential to be able to compete in these markets.

Insurers want to offer that feature to their potential customers -- plan sponsors, pension funds, you name it -- that ultimately benefit the subscribers to those insurer plans.

So when a vertical merger occurs involving a "must have" asset, like the CVS pharmacies and PBM, we have to look really, really carefully and skeptically at the possibility, or we have to carefully assess the possibility that there would be enhanced incentives and ability to make it much more difficult for rival insurers to get access to CVS and Aetna. And that is the case -- that is the case here.

So the concern --

Q. By the way, just pause for a second. You said get access. Maybe that creates an impression like, no, no, no, no, CVS won't allow anybody to have access to their PBM. Is it get access or is it more than that? Is it like providing inferior access?

A. Of course, it is more than that. Thank you for that clarification.

So it is sort of a spectrum of possible concerns. One is they can -- they can do things, engage in behaviors

that make it -- that would raise the cost of rival insurers. They could just hassle them and engage in -- and I will go through a list of what potentially is on the table here.

THE COURT: Could they require them to get their drugs only at CVS?

THE WITNESS: Absolutely.

THE COURT: Would that be legal or illegal, as far as you know?

THE WITNESS: As far as I know, barring any legal constraint on that, I think the more powerful and the more market power CVS has through this merger or other mergers, the more attractive it becomes for them to force rival insurers into exclusive networks.

THE COURT: If they didn't do that, could they at a minimum tell their customers that if you don't go to CVS, either your co-pay will be -- won't be a contribution from us or the co-pay will be much higher?

THE WITNESS: Absolutely. And that has actually happened. About four years ago CVS engaged in an anti-smoking policy where they informed their customers, their Caremark customers, that if they purchased their drugs from a rival pharmacy that sold tobacco products that they would be -- they would pay a $15 extra co-pay.

THE COURT: Was that challenged as to its lawfulness?

THE WITNESS: I don't know. But I did not -- in

doing follow-up, I was not aware of any legal challenge to that.

THE COURT: Interesting.

THE WITNESS: But there are also other mechanisms. For example, in raising the cost of rival insurers or just frustrating access, which would be more of a full foreclosure kind of scenario, CVS-Aetna could develop formularies that exclude important drugs that are in demand by subscribers of rival health insurers.

Dr. Sood articulately outlined the lack of transparency and the failure, for example, to pass on rebates to rival health insurers.

They could design their pharmacy networks in a way that excludes important options like specialty pharmacies. That's key.

As you mentioned, they could force their rival insurers into exclusive CVS/Caremark networks.

They can use information that they gather about rival subscribers and drug spend to impair their ability to compete, to beat them to the punch, for example, on new marketing plans, targeting certain segments of their customer base. And then certainly, you know, the ultimate would be to simply deny to fill prescriptions for their rival -- for rival insurers.

So it is troubling that there is such a robust list

of mechanisms through which CVS and Aetna could effectively foreclose rival health insurers. And again, it is critically important in this case to recognize that high levels of concentration -- high levels of concentration -- are really, really -- really, really important. Right? If rival insurers can't get access to CVS, who do they turn to? Who do they turn to, to avoid any sort of anti-competitive conduct by the merged company?

You don't need complicated economics to figure that out when options are so limited by high concentration that that is determinative of an anti-competitive, anti-consumer effect.

BY MR. BALTO:

Q. Let's step back for just a second here. By exclude, you don't mean totally exclude, it could also mean providing discriminatory access or harming them in some other fashion; right?

A. Correct.

Q. I'm sure that the nice witnesses tomorrow will tell the Court that these insurers are really bright and they could detect those strategies and easily switch to another PBM.

What is wrong with that theory that they could easily detect those strategies, especially for something like PBM rebates and easily switch to another PBM?

A. Well, I think a lack of transparency -- and Dr. Sood alluded to this earlier -- a lack of transparency in terms of whether health insurers even know they're getting the best deal from their PBM. Very hard to tell. There is really not much benchmarking in the industry in terms of whether the prices that an insurer pays are actually competitive or not.

THE COURT: Is there any research that indicates that the average insurer has ever heard of what a PBM is, or have any idea what a PBM is. Before I got this case, I never even heard the expression PBM. Never heard of it. I now know it is a major, major in this entity. But unless you're steeped in this area of business and law, you would never -- I don't think the average insured person would have any idea what a PBM is? They have no idea.

THE WITNESS: I think you're right. I think you're absolutely right.

But I would also add, just to flesh this out a bit, that the lack of transparency in the PBM industry, nobody knows how big the rebates are, do they ever get passed through to the final subscriber. All of this --

THE COURT: Congress doesn't require them to report any of this?

THE WITNESS: And this has triggered state level initiatives to combat this lack of transparency and the power that is held by the PBMs in this very murky -- very murky --

intermediary type --

THE COURT: They're the middlemen.

THE WITNESS: Exactly, they are the middleman, for sure.

BY MR. BALTO:

Q. In fact, Dr. Moss, PBMs have restricted pharmacies from being able to disclose lower cash prices, as we heard today.

Let's go on to the customer foreclosure concerns. Why does access to customers matter for rivals?

A. So the customer foreclosure theory, which you don't hear as much about in vertical mergers because it is different and it assumes a very different fact pattern, the story would go something like: Because CVS now has this killer asset in the form of Aetna as a health insurer and Aetna could conceivably go out and contract with -- an unintegrated Aetna could go out and contract with any pharmacy or any PBM, the logic goes that, now integrated, this very important Aetna asset could be essentially withheld from the market in the fashion that CVS-Aetna would refuse to deal or decline to deal with rival pharmacies and PBMs. And that's a problem. That's an absolute problem. And again, there are many mechanisms that could be utilized to engage in customer foreclosure. And of course, the concern is, if that frustrates competition in the pharmacy and in the PBM markets

by taking Aetna off the table as a potential customer, then prices will go up, drug prices will go up because there is less competition in the upstream markets.

So, again, mechanisms that could be deployed to carry out a customer foreclosure theory would be forcing Aetna subscribers to convert to CVS/Caremark mail order, this is the exclusive networks problem that you just referred to. They could refuse to grant rival PBMs' affiliations to serve Aetna subscribers. That's a necessity to be able to actually do business with a health insurer. They could drive down dispensing fees for the independent pharmacies. They could delay reimbursements to smaller rival pharmacies. They can cherry-pick profitable prescriptions, take the most profitable for themselves and leave the smaller rivals with the very unattractive low-margin prescriptions. They can go through yet another set of activities or forms of conduct that would make it very difficult for rival PBMs and pharmacies to get access to Aetna. And of course, that would impair competition in the pharmacy PBM market, and input foreclosure would impair competition in the health insurer market.

And these are, as I said, very, very concentrated markets with very few options for the impacted consumers, businesses to switch to any other viable option. And that's why high concentration matters.

Q. How does high concentration in the health insurance market make this more problematic?

A. So when you have high concentration in the health insurance market, there are very few -- there are very few options for consumers, for example, who are the victims of an input foreclosure strategy to turn to. Right? So if the market was really well ventilated and we had 10 rival -- robust rivalry between 10 health insurers, very few of these foreclosure concerns would arise in any vertical merger. If we had lots of competition in retail pharmacy and PBMs, foreclosure concerns are minimized, if not eliminated completely. It is only when high concentration matters, and switching options are very limited, and consumers are locked in to one provider, one pharmacy network or PBM network, and one health insurer network that really prompts these concerns about effective highly likely types of foreclosure.

I would also like to point out that the DOJ in their competitive -- in their response to the public comments in this proceeding fairly swiftly dismissed the foreclosure concerns. So, in the context of -- pardon me, Your Honor, I'm looking for --

THE COURT: Take your time.

THE WITNESS: -- the correct page.

It's in here somewhere.

THE COURT: Why don't you just paraphrase it. Give

me your recollection of it in general. If you find it later --

BY MR. BALTO:

Q. Look at slide 17, Dr. Moss.

A. Here we go. I'm sorry. Apologies.

I should have a staple. These aren't stapled together. Staples are very useful.

THE COURT: You have five minutes left. I wouldn't worry about it too much.

THE WITNESS: Let's go back to input foreclosures. Concerns that post-merger CVS and Aetna have enhanced incentives and abilities to foreclose their rival insurers from access to these "must have" networks. There is very little transparency in DOJ's explanation for why that is not a concern. They state two reasons for that. One is that it would be unprofitable for them to cut off or frustrate rival insurers' access to CVS because they would lose the business. They would just lose the business. And their insurer rivals switching to other PBMs and pharmacies are significant enough to make this an unprofitable strategy.

And the second part of the rationale, according to DOJ, as I read it, is Aetna's inability to capture those customers who are on the short end of the stick because now they can't get access to a really "must have" input that Aetna can't capture those customers.

I find, as an economist who studies this stuff 24/7, I find that to be a very murky and ill-supported rationale for why the Court should not consider -- why the government did not consider input foreclosure, and I think it really deserves a hard look.

Of course, we don't have access to confidential documents that were produced in an investigation. We do all of our analysis on the basis of publicly available information.

But just to finish up this theme, DOJ's logic as to why customer foreclosure is not a concern in this case, meaning cutting off Aetna from rival PBMs and rival pharmacies, is that it is unlikely because Aetna's relatively small share in the commercial insurance markets -- because Aetna has a small share in the commercial insurance markets -- I have trouble with that, significant trouble with that because Aetna competes in more than just commercial insurance markets. They compete in Medicare Advantage. They have other insurance products. It doesn't matter that they have a small share in commercial markets. Any of their insurance products are going to need to have inputs from pharmacy and from PBM services. So I found just reading the government's comments, response to the comments, I found that to be -- to lack a lot of transparency and clarity as to why that was a reason why we should not worry about customer

foreclosure.

Q. So those two sentences on vertical foreclosure don't give the Court much guidance about why there aren't concerns?

A. Correct.

Q. Going back to the pharmacy-related concerns, is there any other information you've recently gathered that sort of raised your concerns over pharmacy-related issues?

A. Well, I think, to return to the theme of Centene, the proposed or possible Centene-WellCare Health merger we would have yet another vertically integrated -- another vertically integrated insurer, pharmacy provider. Probably that would be fourth or fifth in the lineup. They would be the fourth or fifth largest firm.

Q. Going back to the concerns of Dr. Wohlfeiler, do you think those concerns are more general or unique to AHF?

A. No, I think they're much more -- they are generalizable to, not only at-risk populations that he so clearly articulated, but to any populations. And to come full circle, we're talking about consumers in this case in the PDP markets who are senior citizens, who are low-income consumers, who are sometimes at-risk individuals. And those impacts are really significant. And we're also talking about, not only those consumers, but the effects of higher costs and higher premiums and higher rates on taxpayers who fund the Medicare Part D programs.

In terms of the vertical concerns, I think the impacts would be on all of us. All of us would face significantly higher premiums, higher drug costs, as a result of this merger but, more generally, this sort of fundamental restructuring in the industry that this merger really contributes to.

Q. So will competition be fully restored and consumers be protected if the Judge signs the proposed Final Judgment?

A. I do not think they would be at all. I think consumers would be greatly -- competition would be imperilled, and consumers would be greatly at risk.

THE COURT: Thank you, ma'am.

THE WITNESS: Thank you.

THE COURT: You may step down.

(Witness excused)

THE COURT: All right. Counsel, we'll reconvene tomorrow morning at 10:45. We will hear from CVS, the government's, and Aetna's three witnesses.

I believe your first witness is the two-hour witness; isn't that correct?

MR. PITT: Yes, Your Honor.

THE COURT: We will hear from that one first. We probably won't finish it before lunch, but we might, it's possible. And then we will hear from the other two witnesses in the afternoon.

So I will see you in the morning.

Mr. Habash, come up.

(Bench conference not reported)

(Proceedings adjourned)

CERTIFICATE OF OFFICIAL COURT REPORTER

I, Patricia A. Kaneshiro-Miller, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/ Patricia A. Kaneshiro-Miller — June 4, 2019

PATRICIA A. KANESHIRO-MILLER — DATE

D

E

F

G

H

Q

R

S

T

U

V

W

Y

Z